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Biological Psychiatry

Lessons Learned From the Coronavirus Health Crisis in Madrid, Spain: How COVID-19 Has Changed Our Lives in the Last 2 Weeks

To the Editor:

As I write this letter on April 2, 2020, Spain is the country with the world's second-highest number of COVID-19 deaths, a figure that now exceeds 10,000 here, accounting for over 20% of world's total death toll from this disease. In what just a few weeks ago used to be some of Europe's liveliest cities—Madrid and Barcelona—the streets are empty, something that did not happen even during the Spanish Civil War. The total number of deaths in my city of Madrid alone is over 4000, and the number of intensive care units (ICUs) has increased 7-fold. In normal times, my hospital had 20 ICU beds, and the number as of today is 116. Despite that, the factor that has proven key for mortality rates, the availability of ICU beds, collapsed a few days ago. New ICU beds have been set up in the library, rehabilitation gym, operating rooms, and recovery rooms. The hospital has been completely transformed in less than 2 weeks. We even have a military field hospital run by Doctors Without Borders that handles triage. Only patients who have pneumonia and are in serious condition are admitted; most COVID-19–positive patients are sent home to be treated by their general practitioners or sent to nearby converted hotels. Hospitals are almost entirely filled with COVID-19 patients, even though the number of patients is 50% more than the maximum capacity. Today, we have 863 COVID-19 patients. We have had up to 400 patients in the emergency room waiting for a bed (or a couch).

The number of psychiatric beds in Madrid has been drastically reduced by over 60%. Most large university hospitals do not have inpatient psychiatric units anymore, as almost all beds have been freed up for COVID-19 patients. Day hospitals, rehabilitation units, and vocational units for psychiatric patients have all been closed. The number of patients attending psychiatric Emergency Department has been reduced by 75%, but this seems to be the case for almost all other medical specialties: even cardiologists say that there are fewer heart attacks, and neurologists say that there are fewer strokes.

We have had to adapt the services provided in my Department of Psychiatry to the new necessities. We usually have 6 staff (3 psychiatrists, 3 psychologists) in our Liaison Program. The Psychiatric Liason Department has now 25 staff. They are split into three major programs.

The first one is to take care of staff mental health. Some years ago, in 2004, Madrid was hit by the worst terrorist attack in its history, with 10 explosions in commuter trains resulting in 193 casualties and more than 2000 injuries. Hospitals were suddenly full, and health professionals worked night and day to save as many lives as possible, causing acute trauma for many health professionals. This is different; this is acute trauma occurring chronically day after day. Some professionals develop a sort of learned helplessness. It does not matter how hard they work and how well they do their jobs—the next day there is no reward, only punishment: more patients and more deaths. There is no controlling a demand that increases exponentially. In this program, we run small groups (no more than 5 or 6 people, in order to maintain physical distancing—social distancing is something that we have never practiced and is not in our genes) in the ICU, emergency room, and wards with the most demand. The staff is truly overwhelmed by the combination of fear, guilt, knowledge that they are not saving lives that they know could be saved under different circumstances, frustration at not having a proper treatment and at not being able to predict who is going to do poorly, and more. Most health professionals are doing jobs that they have never done before or at least have not done for a very long time. Many psychiatrists are working in COVID-19 wards or in the emergency rooms of general hospitals. Working in groups helps professionals who are dissociated most of the time (for good reason) to vent emotions. Most imagine that if they were watching what is happening in a movie with their families, they would be crying. Action does not leave room for emotions, but this will eventually have detrimental consequences for their mental health. This program also takes care of staff who are at home and infected. They feel guilty for not being there to help their colleagues and, in most cases, for having infected their families—sometimes, especially when this involves elderly parents, with dire consequences. Many professionals want individual counseling or ask for hypnotics to get some sleep. We have a phone number and email address so that professionals can contact us, and we see them the same day.

A second program within the Liaison Department takes care of relatives of patients who are unable to visit them, and we have set up videoconference call systems so that they can stay connected. This has proven very helpful and is much appreciated by all concerned. As it takes time to procure these devices and, in some hospitals, information technology security has not allowed free Wi-Fi connection, this is something that needs to be set up well in advance. Such videoconferences in the hospital will reduce anxiety in patients and their families.

A third group is in charge of the death process. Doctors call us when they know someone is going to die, and we inform relatives, ask for verbal consent to administer sedation, and organize a "farewell" visit—only one visitor is allowed, and that cannot be someone who is at risk or COVID-19–positive, so often there is no visit, and patients die with no one there for them; in these instances, we hold videoconferences to inform family about the death and provide counseling. No funerals are allowed. People die in the most unthinkable solitude: no hugs, no last words, no handholding. If they do not receive sedation, they die from suffocation. We also have a program to identify pathological grief and have a follow-up phone call 3 weeks after the death. Not having any rituals surrounding death and the circumstances of these events make us think that we will have many cases of delayed and pathological grief.

All three programs run 24/7 and we have had to organize shifts. It helps that there are no weekends, as all days are

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the same when you cannot leave your home, schools are closed, etc.

Another reason for consulting the Psychiatric Liaison Department is when patients want to leave the hospital or refuse to take medications. In this case, it is important to know whether the reason for this behavior is a previous mental disorder (in which case, it is a public health matter, and no further psychiatric involvement is needed). In many cases, patients are in a state of confusion and not aware of the consequences of their actions.

I also believe that, owing to fear of contagion, police and the population in general have less patience with psychiatric patients who do not follow rules such as social distancing. This makes them especially vulnerable to abuse and ostracism by society.

Our inpatient psychiatric unit is one of the few that remain open in Madrid. We have one section for COVID-19–negative patients, one section for potential victims awaiting test results, and another section for COVID-19–positive cases. Most infections occur because there are no defined clean and dirty paths within the hospital (e.g., there is vertical infection through elevators, stairs, and such, infection by individuals who move from one place to another, or infection via patients who are taken to Radiology). It is important that there be separate spaces, staff, and paths for non–COVID-19 and COVID-19 psychiatric inpatient units.

All appointments are done by videoconference or telephone. We have not canceled a single one. Nurses go to the homes of those who need medications or other services. Another problem we are facing is that, in Spain, most patients with severe mental disorders live with their parents (e.g., a 50-year-old patient with chronic schizophrenia). Some have parents or caregivers who have died. These patients are by themselves and unable to take care of their basic daily needs. There is, of course, a social component of the health crisis for many of our patients.

There have been insufficient safety measures including wearing of masks. Physicians and patients are now required to wear surgical masks, but this has been implemented only in the last week. Despite controversies about this (1), it should have happened much sooner. Eighteen percent of our staff has been infected, and health professionals constitute 14% of all infected individuals in Spain. I believe that most of these cases are transmitted by colleagues, rather than by patients. People may be asymptomatic for up to a week before being symptomatic, so many of our colleagues that we believed had less risk have been the cause of contagion among professionals. When COVID-19 patients are treated, in addition to a mask, staff need to wear gloves and gowns, and, if there is physical contact, personal protective equipment such as glasses or face shields. The problem is that when patients are very agitated, there is no time to put on personal protective equipment, or it is easily broken in the process of physical restraint. As many staff will be infected, it is important that replacement staff be prepared and trained ahead of time, when that is a possibility.

There have been many deaths among the elderly in nursing homes and other long-term care facilities. We have also had some deaths in residential facilities for individuals with intellectual disabilities and autism. Rather than taking sick residents to hospitals, the residences are converted to treatment facilities. We also have some hotels near the hospital that have been converted, and less severely ill patients are treated there. The government now has the power to appropriate any public or private property in the public interest.

One of the many mistakes the Spanish government made was that people with intellectual disabilities or autism were allowed to go out into the streets. This was done with the best of intentions (to minimize behavioral problems in this vulnerable population). However, this is precisely a population that must not become infected because 1) managing them in the hospital is very difficult for both them and the system, especially now; 2) a relative will also be infected, as they need someone with them; and 3) sadly enough, they are not eligible for ICU care.

As an advisor for my hospital's crisis committee, most days I visit all the different wards and units in the hospital. The most distressing for me is the gym, where we now have around 70 beds, all with elderly victims who have been refused ICU admission when needed. They are aware of this, and of course they are all by themselves. You cannot imagine how loud the absolute silence there resonates, despite the large number of patients. I am sure that they are all reliving their lives. We should all learn from this lesson and use it when it is our turn in the future. And the worst is yet to come. Take care.

Celso Arango

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